Basic Health™

You must return this form

Recertification Form

<MMMM/DD/YYYY>

I.D. #: *SSN*

<NAME>
<ADDRESS>
<CITY, STATE ZIP>

<GROUP I.D. & LANGUAGE CODE>

To continue your health care coverage, you must complete, sign, and date this form. Basic Health must receive all required documentation by <mm/dd/yy>.

1. Print your current street address and phone number:

_____

Street address City State ZIP

(_____)_____

Phone number

2. Are you or your spouse self-employed or do you have rental income? ☐ Yes ☐ No

   If you are self-employed, write your Unified Business Identifier (UBI) number here: _____

   For questions about UBI numbers, call the Department of Licensing at 360-664-1400 or the Department of Revenue at 1-800-647-7706.

   ☐ Check here if you do not have a UBI number because your business is not registered with the state.

3. List the first and last names of your spouse and dependents, if any, even if they are not enrolled in Basic Health (BH).

   Spouse's name _____

   Dependent's name and birth date _____

   Dependent's name and birth date _____

   Dependent's name and birth date _____

   Dependent's name and birth date _____

You must read and sign the statement on the back of this page.

Basic Health™

I understand that:

- I must provide proof of my gross family income (before taxes and deductions) and report income changes that would change my premium or eligibility to BH within 30 days after the end of the month that the new income was received.
- My signature on this form authorizes BH and the Department of Social and Health Services (DSHS) to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family within the timeframes shown in the *Basic Health Member Handbook*.

I authorize any health plan or medical provider to give medical records for me or my children to BH, for purposes of participation in the BH/Medical Assistance Administration programs.

I declare, under penalty of perjury, the information I have given on this recertification form and the documents provided are true, correct, and complete to the best of my knowledge. I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under Basic Health or additional premium amounts due, and may face other penalties, prosecution, and collection.

Must be signed by you and your spouse

X_____ X_____

Your Signature Date Spouse's signature Date

Signatures of children age 18 and over who receive Basic Health coverage

X_____ X_____

Signature Date Signature Date

X_____ X_____

Signature Date Signature Date

Privacy statement: Washington State law may require disclosure of any information you submit as a public record. Basic Health is administered by the Health Care Authority (HCA); our Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.